National Alliance of Safety-Net Hospitals

March 16, 2020

Ms. Lindsey Baldwin
Ms. Emily Yoder
Division of Practitioner Services,
Hospital and Ambulatory Policy Group
Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Ms. Baldwin and Ms. Yoder:

The National Alliance of Safety-Net Hospitals seeks guidance from the Centers for Medicare & Medicaid Services (CMS) on the provision of health care services via telehealth for Medicare beneficiaries being examined or treated for COVID-19. The delivery of such services in this manner was included in H.R. 6074 - Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (now Public Law No: 116-123), but questions remain about who is eligible for these services, the extent of services that can be provided in this manner, how providers are to code for such services, and how they will be paid for their efforts. With this in mind, we seek guidance for our members so they can serve their patients effectively and comply with all Medicare requirements and guidelines.

Specifically, we seek guidance on the following matters.

1. What constitutes a "covered patient" under these circumstances? Are the telehealth services in question limited to screening and treatment for potential COVID-19 patients only? For all patients? For medical problems other than COVID-19 to facilitate "social distancing" at this time? Does the new law's waiver apply to all Medicare beneficiaries regardless of diagnosis?
2. The legislation states that for patients to qualify for enhanced access to telehealth services they must have an established relationship of three years with the provider in question. Does this mean that the patient would not qualify for telehealth services if a provider with an established relationship of three years refers that patient to another provider (such as a specialist) specifically for COVID-19 assessment or treatment?
3. What CPT-4 codes should providers use when providing telehealth services under this waiver?
4. We seek addition clarification on coding matters for telehealth services delivered in the home.
    a. Codes covered under CMS's telehealth program do not include home services (new patient – 99341-99345; established patient – 99347-99350).
    b. Virtual check-ins are not currently included among approved telehealth services.
    c. Established patient visit codes for services delivered through provider-based facilities result in facility fees.
5. What diagnosis codes should providers use when they have ordered testing for patients suspected of having COVID-19 but test results are not yet available? We understand that we cannot code

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for COVID-19 until test results confirm the presence of the condition but would like to know how to code to ensure reimbursement for COVID-19-related telehealth services prior to diagnosis of the patient's condition.

6. Does CMS envision having time-based codes, and if so, will that require documentation?
7. Do health systems submit claims differently when they have providers located in areas serviced by different Medicare Administrative Contractors?
8. When will it be appropriate for providers to waive co-pays for Medicare patients? Will this be only for COVID-19-related telehealth encounters or all such encounters? Will providers be reimbursed for these waived co-pays and if so, when and how will this happen and what, if anything, do providers need to do on their end to ensure this reimbursement?

NASH appreciates your attention to these matters, welcomes any questions you may have about them, and looks forward to a response either directly or through additional CMS-issued guidance on the health care sector's role and response in the COVID-19 health emergency.

Sincerely,

Ellen Kugler, Esq.
Executive Director